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**Community Pharmacists: Members or Bystanders
of the Primary Care Multi-Disciplinary Team?**

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Abstract

Objectives: This study investigated who community pharmacists (CPs), general practitioners (GPs) and practice nurses (PNs) included in their multi-disciplinary team (MDT), whether they felt part of the MDT, barriers and facilitators to multi-disciplinary working and whether the extent of the CP's clinical role influenced being part of a MDT.

Methods: Survey to CPs, GPs and PNs in south England. Participants were recruited using social media, journal ads and face-to-face visits/phone calls using NHS and professional networks. Responses were analysed using descriptive statistics, bivariate analyses and content analysis for open text.

Key Findings: 214 GPs, 147 PNs and 162 CPs responded. Nearly all PNs (98%) and GPs (99%) considered themselves part of a MDT compared to 78% of CPs. Working in isolation, lack of time and a lack of information sharing were the most common reasons for not feeling part of a MDT. The extent of the CP's clinical role was not related to feeling part of a MDT.

Conclusions: Greater investment is needed in the structures to support multi-disciplinary working in terms of time and resources, as well as a greater awareness of MDT members' roles and potential contribution.

Keywords

Community pharmacy; general practice; primary care team; practice nurse; team working;

Background

The benefits of multidisciplinary working in primary health care are well recognised: improved patient care through increased opportunities for communication, sharing of knowledge, cross-fertilisation of ideas and a sense of partnership [1]. Many factors can influence the effectiveness of teamwork including dedicated time and resources, co-location and staff commitment [2].

With increased life expectancy and rising numbers of people living with chronic conditions, there is the potential for community pharmacists (CPs), as part of the multi-disciplinary team, to play a significant role in patient care. In the UK, there has been continued expansion of the CP's role to take on more clinical tasks to release capacity in general practice. CPs are seen to be in an ideal position to take on the routine management of long term conditions and there is evidence that they can do this [3]. However, establishing collaborative relationships between general practice and community pharmacy has proved difficult [4]. Poor integration of CPs on primary care teams may be one reason why the CP's clinical role is not more developed.

This study explored the integration of CPs into the primary care multi-disciplinary team (MDT): whether CPs, general practitioners (GPs) and practice nurses (PNs) saw themselves as part of an MDT, who was on their respective MDTs, barriers and facilitators to MDT working and whether the CPs' clinical role influenced MDT working.

Method

A cross-sectional survey of CPs, GPs and PNs was conducted across the southern England in 2013. The survey included demographic information, respondents' views on multidisciplinary working and whether they felt part of a MDT. CPs were also asked about the extent of their clinical role. The survey also included two validated questionnaires on organisational climate and personality, discussed elsewhere [5].

Recruitment used advertisements in professional journals and the use of NHS research and professional networks via email, website posts and Twitter; flyers were posted to practices and pharmacies; and telephone calls and visits were made to practices and pharmacies. The questionnaire was analysed using descriptive statistics, chi-square and Mann-Whitney tests and directed content analysis [6] for free text.

Results

214 GPs, 147 PNs and 162 CPs responded. Due to the undirected recruitment methods, precise response rates cannot be calculated.

CPs were slightly younger than GPs and PNs (Table 1). In addition, significantly fewer CPs had postgraduate qualifications than GPs ($\chi^2=74.0$, $p<.005$) and PNs ($\chi^2=56.4$, $p<.005$).

Most respondents worked in urban settings, with more urban CPs (81%) than GPs or PNs (both 69%). Over half the GPs and PNs were co-located with a pharmacy. Most CPs (75%) were not co-located with a practice. Over a third worked in independent pharmacies.

An open-ended question asked what support participants received, if any, from their workplace. These were coded from 1 to 4 from no support to extensive support (support/advice/training, from many sources). Level of support was significantly related to professional group ($\chi^2=114.00$, $p<.001$; Cramer's $V= .33$). PNs reported significantly more support than GPs ($\chi^2=55.8$, $p<.001$; Cramer's $V=.40$) and CPs ($\chi^2=78.2$, $p<.001$; Cramer's $V=.51$). GPs received more support than CPs ($\chi^2=28.9$, $p<.001$; Cramer's $V=.28$).

Most PNs (98%) and GPs (99%) considered themselves part of a MDT compared to 78% of CPs. Significantly more CPs did not consider themselves part of a MDT than either GPs ($\chi^2=43.2$, $p<.001$) or PNs ($\chi^2=26.9$, $p<.001$). Of those CPs part of a MDT, 15% did not include either GPs or PNs on their team. In all, 42% of GPs and 41% of PNs listed CPs on their MDTs. When specifically asked if they considered a CP part of their team, 56% of GPs and 57% of PNs stated yes.

There was an association between level of support and being part of an MDT, [$\chi^2=9.03$, $p=0.029$, Cramer's $V=.14$]. CPs at multiples/chain pharmacies reporting significantly more support than CPs at independent pharmacies ($\chi^2=28.91$, $p<.001$; Cramer's $V=.43$).

Of those GPs and PNs who did not consider a CP part of their MDT, the most common reason was they had no or little contact with CPs, with a few seeing them external to the NHS or too commercially focused. The top 5 most frequent barriers are in table 2. Some CPs suggested there was a need to educate GP staff about the CP's role.

A measure of CPs' level of clinical work was developed based on how frequently they delivered advanced/enhanced pharmacy services. No relationship was found between extent of clinical role and years in practice, pharmacy type or whether or not a CP felt part of a MDT.

Discussion

Most GPs and PNs felt part of a MDT, although these did not always include CPs. Fewer CPs felt part of a MDT. CPs seemed more likely to include GPs and PNs on their MDTs than vice versa. Findings suggest a need to support MDT working which may be more difficult for CPs in independent pharmacies.

In 2009 a qualitative synthesis of research investigating multidisciplinary primary care team working found that investing time and resources towards team building was crucial [12]. Another theme from this synthesis was the importance of team interactions and work relations, which can be supported by developing a collective group identity at the practice level [7]. Indeed, the importance of developing a team or practice identity has been

previously described in research exploring the integration of nurse and pharmacist prescribers within the general practice team [8].

Even for those who appear part of the MDT, there may be difficulty accepting their legitimacy within the team. In a systematic review of advanced practice nursing [9], a key contributor to the lack of their perceived legitimacy was role uncertainty, including scope and domains of practice. Likewise for CPs, there may be a lack of awareness of CPs' potential role and, for a few, an abiding perception of the CP's commercial role.

Conclusion

To enhance MDT working, there needs to be more resources devoted to developing CPs' role in the team, greater awareness of MDT members' roles and contribution, use of effective communication strategies and the development of a shared group identity.

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Table 1. Sample demographics according to professional group.

	GP (N=214)	PN (N=147)	CP (N=162)
Gender			
Male	105 (49.1%)	3 (2.0%)	69 (42.6%)
Female	109 (50.9%)	144 (98.0%)	93 (57.4%)
Age (in years)			
Mean (SD)	45.2 (8.8)	48.9 (8.3)	39.8 (11.3)
Range	25 - 63	27 - 70	23 - 69
Year of registration			
Mean (SD)	1992 (9.3)	1987 (9.5)	1997 (11.7)
Range	1970 - 2013	1964 - 2009	1968 - 2013
Years in practice			
Mean (SD)	15.0 (8.6)	13.6 (8.1)	14.3 (10.8)
Range	0 - 35	.25 - 40	0 - 51
Postgraduate further qualifications	(N=212)	(N=146)	
One or more qualification(s)	171 (80.7%)	116 (79.5%)	60 (37.0%)
Qualified prescribers	N/A	29 (19.7%)	13 (8.0%)

Table 2. Top 5 barriers to being part of a multidisciplinary healthcare team, as reported by each professional group.

	GP (N=201)	PN (N=140)	CP (N=152)
1	Insufficient time (55.7%)	Poor communication (34.3%)	Poor communication (32.9%)
2	Geographic separation (25.3%)	and Insufficient time (34.3%)	Lack of understanding of each other's roles (21.1%)
3	Lack of face-to-face contact (16.4%)	Lack of face-to-face contact (12.9%)	Insufficient time (20.4%)
4	Poor communication (15.9%)	Prohibitive workload (12.1%)	Geographic separation (18.4%)
5	Prohibitive workload (12.4%)	Lack of understanding of each other's roles (10.0%)	Lack of shared access to patients' medical records (13.8%)